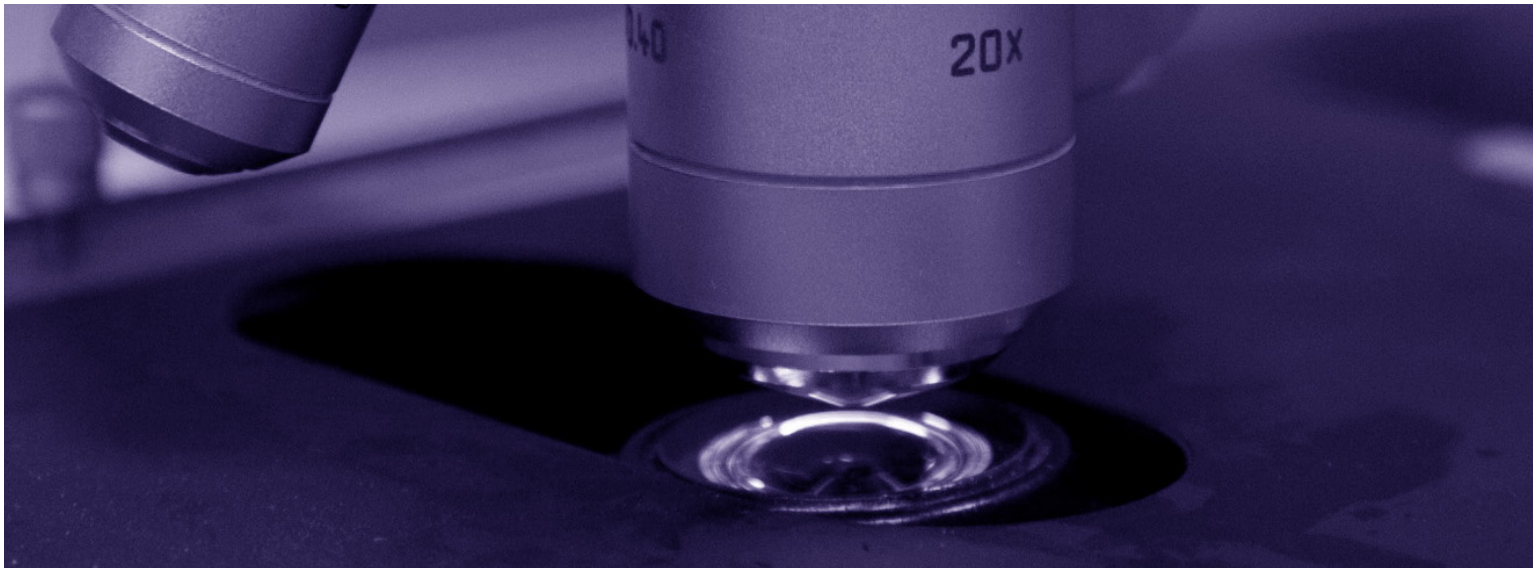
Death Investigation Oversight Council

Annual Report 2014



Ontario

Death Investigation Oversight Council Annual Report 2014

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25 Grosvenor Street
15th Floor
Toronto ON M7A 1Y6

Conseil de surveillance des enquêtes sur les décès

25, rue Grosvenor
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Toronto ON M7A 1Y6

Ontario
Death Investigation Oversight Council
Conseil de surveillance des enquêtes sur les décès

January 1, 2015

The Honourable Yasir Naqvi
Minister of Community Safety and Correctional Services
18th Floor, 25 Grosvenor Street
Toronto, ON M7A 1Y6

Dear Minister:

On behalf of the Death Investigation Oversight Council and pursuant to section 8 (7) of the Coroners Act, R.S.O. 1990, I am pleased to forward the Annual Report of the Council for the calendar year ending December 31st, 2014.

Sincerely,

The Honourable Joseph C.M. James
Chair

Message from the Chair

The Death Investigation Oversight Council completed its fourth year of business and is pleased to report on its activities in this Annual Report.

In the first two years of its mandate, the Council focused on setting up its operations and co-sponsoring KPMG's systemic review of Ontario's death investigation system. A status report on those recommendations is included in this annual report. The third year focused on making sensible recommendations to enhance accountability and transparency in the system. In its fourth year, the Council continued to provide practical recommendations to modernize the death investigation system and support a high quality service delivery. In addition, the Council focused its role on meeting all aspects of its mandate, including the appointment of senior personnel and financial resource management.

In 2014, the Council developed recommendations that were practical, feasible and effective. The recommendations focused in two key areas: the modernization of the coronial system and a high quality death investigation system.

The continued modernization of the coronial service is critical for the provision of the best possible death investigation services. To support this, the Council recommended changes to ensure fair and transparent recruitment, time limited Orders-in-Council (OICs) and ongoing professional development.

The Council developed a set of principle statements that should drive and are relevant to support a quality death investigation system in Ontario. With the implementation of these principles, Ontario will continue to have a high quality death investigation system that supports the diverse needs of Ontarians.

In 2014, the Complaints Committee began meeting with complainants to gather information to better support the public complains process. In addition, the Committee continued to strengthen its medical understanding and build linkages with the Quality and Standards Committee. The Quality Committee and Standards Committee merged to better meet the mandate of the Council. The Committee focused on setting the stage for the 2015 evaluation of the first year of the forensic pathologist-coroner initiative.

The Inquest Committee worked to establish a strong foundational understanding of the inquest system in Ontario, with a focus on identifying areas for improvement.

The Strategic Planning Committee was established to develop a strategic plan for the Council. In mid-2014, the Council adopted the vision and strategic plan.

Finally, a new Committee was established focusing on the area of financial resource management. The Committee focused on defining the Council's role in this area.

All this work could not have been accomplished without the dedication of every member of Council. I would like to convey my deep appreciation to all members for their continued focus on improving the death investigation system. It is through their effort and dedication that the Council has continued to provide practical, effective advice to the Minister, the Chief Coroner, and the Chief Forensic Pathologist to ensure the death investigation system best meets the needs of Ontarians.

Sincerely,

The Honourable Joseph C.M. James

Overview

In response to the need for accountability and enhanced oversight, the Death Investigation Oversight Council (DIOC) was established in December 2010.

Mission

The Council is an independent oversight body committed to serving Ontarians by ensuring death investigation services are provided in an effective and accountable manner. As an advisory agency, the Council provides oversight to coroners and forensic pathologists in Ontario and administers a public complaints process.

Mandate

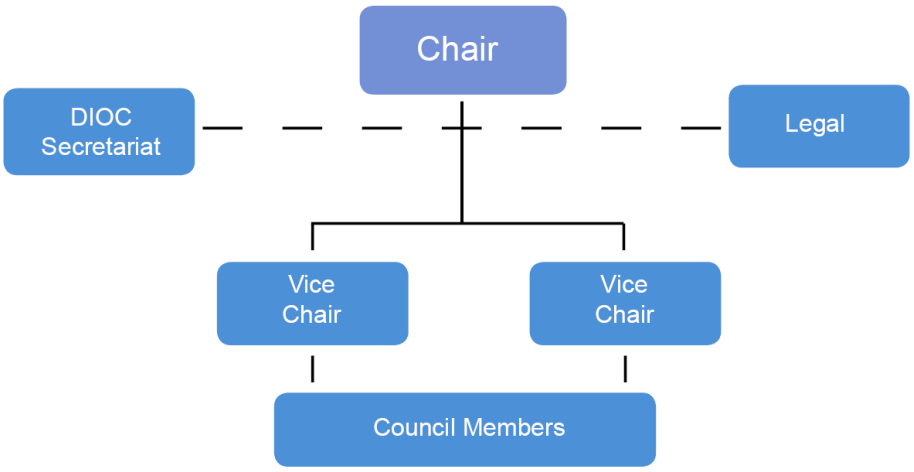
The Council oversees the Chief Coroner and the Chief Forensic Pathologist by advising and making recommendations to them on:

1. Financial resource management;
2. Strategic planning;
3. Quality assurance, performance measures and accountability mechanisms;
4. Appointment and dismissal of senior personnel;
5. The exercise of the power to refuse to review complaints under subsection 8.4 (10) of the Coroners Act;
6. Compliance with the Coroners Act and its regulations; and
7. Any other matter that is prescribed.

Organization

While operating independently within its mandate, the Council is accountable to the Minister of Community Safety and Correctional Services. The Council is headed by the Chair and supported by two Vice-Chairs.

The Council is supported by a Legal Counsel, and a Secretariat which manages the day-to-day operations of the agency.



The DIOC Secretariat is comprised of four individuals:

- Fiona Foster, Manager
- Danielle Hryniewicz, Senior Policy Advisor*
- Sienna Leung, Policy Analyst
- Stephanie Romain, Administrative Assistant

*Senior Policy Advisor went on leave and was replaced by Craig Allan in November 2014.

Board Membership

DIOC is made up of medical and legal professionals, senior heath executives, government representatives and members of the public who collectively have the knowledge and expertise to provide quality oversight.

The selection of public members is made through the Public Appointments Secretariat and government representatives are nominated by their respective ministries. The Lieutenant Governor in Council then makes appointments to the council for a three-year term. All members are serving until Dec 16, 2016, unless noted below.

Voting Members

The Honourable Joseph C.M. James, former member of the Ontario judiciary (Chair)

Emily Musing, Executive Director, Pharmacy, Clinical Risk and Quality/Patient Safety Officer, University Health Network (Vice Chair)

John Pearson, Counsel, Crown Law, Ministry of Attorney General (Vice Chair)

Dr. David Williams, Public Member

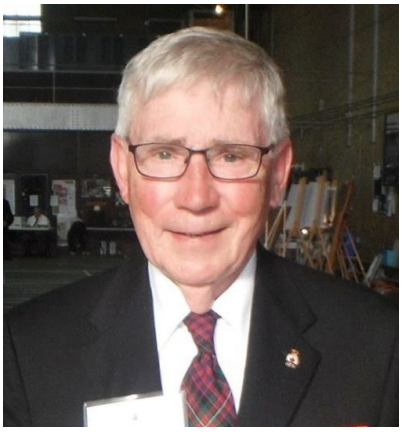
Denise St-Jean, Public Member

Dorothy Cynthia Prince, Public Member

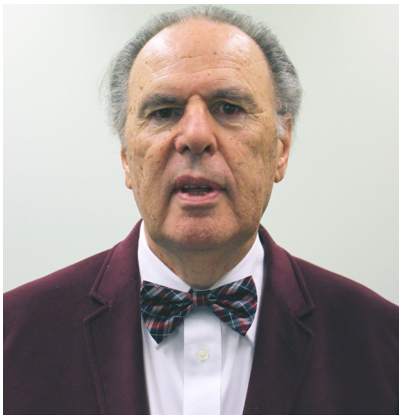
Dr. Fiona Smaill, Professor, Department of Pathology and Molecular Medicine, Faculty of Health Sciences, McMaster University

Lidia M. Narozniak, Assistant Crown Attorney, Crown Law, Ministry of Attorney General

Lori Marshall, Public Member



William James Shearing, Public Member



William Mclean, Public Member[1]

Lucille Perreault, Public Member[2]

[1] Appointed until May 4, 2017 [2]Appointed until August 13, 2017

Non-Voting Members

Dr. Dirk Huyer, Chief Coroner

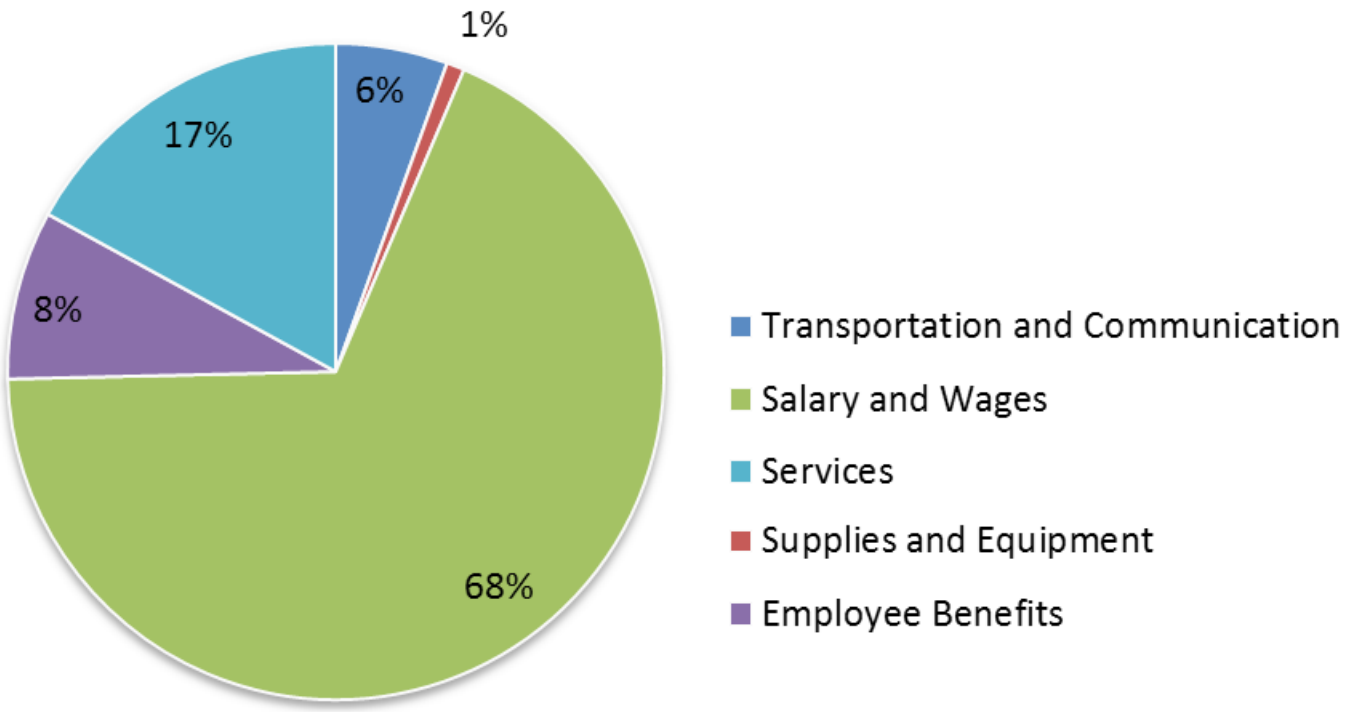
Dr. Michael Pollanen, Chief Forensic Pathologist

Funding

Funding for DIOC is obtained through a standard yearly budgetary process. Funding amounts are appropriated by the legislature through the Ministry of Community Safety and Correctional Services.

The total budget allocated for DIOC in fiscal year 2013-14 was $432,200. The chart below shows a breakdown of DIOC's allocated budget:

Budget Allocation for Fiscal Year 2013-14



Key Activities in 2014

1. Building a high quality, professional service

The continued modernization of the coronial service is critical for the provision of the best possible death investigation services. To support this, the Council recommended changes to ensure fair and transparent recruitment; time limited OICs and ongoing professional development.

The Council recommends coroners be recruited and appointed through an open, fair and transparent appointment process and be appointed on the basis of skills, experience, regional need and be reflective of the diverse communities within Ontario. Appointments should be time limited and require approval of the Chief Coroner. Coroners should undergo a formal education training program that includes initial training, in-service training and clearly articulated requirements to maintain the designation. The Council believes these recommendations will make the coronial service in Ontario a model of excellence.

2. Supporting a modern and high quality death investigation system

The Council worked with key partners in 2014 to implement the recommendations Council made in 2013 to improve the death investigation in Ontario. The Council's 2013 recommendation that forensic pathologists act as coroners in in criminally suspicious and homicide cases was implemented in Toronto in July 2014. The Council will begin the work required to conduct an evaluation of the initiative in 2015. In addition, the Council has begun working with key partners to implement the recommendation that Council provide advice to the Chief Coroner on section 26 discretionary inquest appeals.

The Council developed a set of four principle statements that are relevant to support a quality death investigation system in Ontario:

1. Quality death investigations will be delivered in a way that respects the diverse population of Ontario.
2. A quality death investigation system in Ontario will be innovative and evidence-informed.
3. Quality in Ontario's death investigation system is achieved when services are monitored, held accountable and all aspects of evaluation are transparent.
4. Death investigations in Ontario will be provided by professionals who embody and put into practice the values of sensitivity and respect.

With the implementation of these principles, Ontario will continue to have a high quality death investigation system that supports the diverse needs of Ontarians. The Council hopes to see these principles enshrined in key guiding documents within the Office of the Chief Coroner and the Ontario Forensic Pathology Service.

3. Fulfilling Council's Mandate

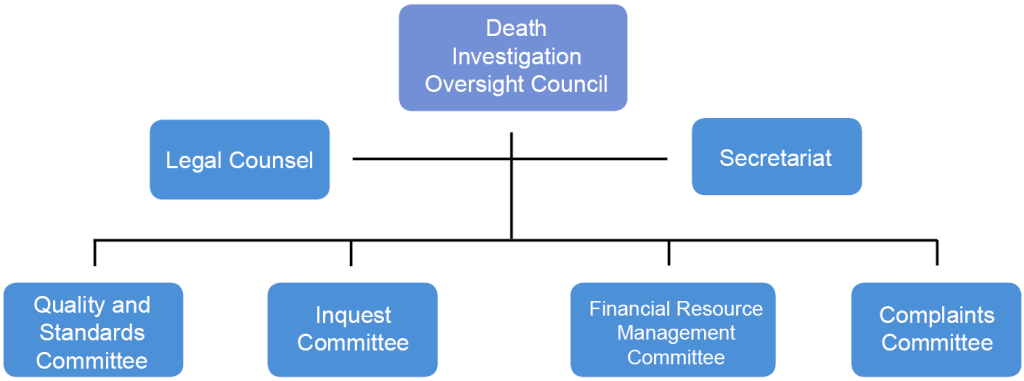
The Council undertook a series of activities to broaden the work of the Council to meet its legislated mandate. This included involvement in the appointment of senior personnel within the Office of the Chief Coroner. As the Council expanded its role to fulfil the mandate, the Financial Resource Management Committee was established. To support the provision of quality death investigation services, the Committee will act as a strategic advisory group by providing oversight, advice and recommendations on the overall financial management strategies and priorities of the Office of the Chief Coroner and the Ontario Forensic Pathology Service.

The Council undertook a strategic planning process in 2014, with a focus on identifying the mission, values and goals of the Council. This plan will ensure the work the Council does aligns with the mandate of the Council and the public interest.

Committees

The Council has four committees that are headed by Committee Chairs. These are: Complaints Committee, Inquest Committee, Quality and Standards Committee and Financial Resource Management Committee. Each of the four committees is responsible for carrying out its established mandate.

The Complaints Committee and Inquest Committee are standing committees of the Council. Committee membership is determined based on committee need and Council member interest.



Complaints Committee

The Complaints Committee is responsible for the review of complaints regarding a coroner, pathologist or certain other persons referred to under the Coroners Act who have powers or duties for post-mortem examinations. The goal of reviewing complaints is to help improve Ontario's death investigation system. In reviewing a complaint, the Committee considers the actions taken during the course of a death investigation and if required, provides recommendations.

Inquest Committee

In support of providing a quality death investigation system in Ontario, the Committee will research and examine systems of inquest to advise and recommend to Council best practices and policies.

Quality and Standards Committee

The Committee measures, monitors and evaluates the performance of Ontario's death investigation system and will recommend to the Council initiatives, practices and standards that will provide Ontarians with a high quality death investigation system.

Financial and Resource Management Committee

In support of providing a quality death investigation system in Ontario, the Committee will act as a strategic advisory group by providing oversight, advice and recommendations on the overall financial resource management strategies and priorities of the Office of the Chief Coroner and Ontario Forensic Pathology Service.

Appendix

Status update on the Death Investigation Oversight Council DIOC Recommendations to the Minister - April 26, 2013

Recommendation
Appointing forensic pathologists as coroners for cases of suspicious death or homicide.

Current Status
1. Forensic Pathologist-Coroners appointed at the Provincial Forensic Pathology Unit in July 2014. Future province-wide roll out is pending evaluation of the initiative.
2. DIOC to begin the evaluation of the initiative in 2015.

Recommendation
Allowing the Death Investigation Oversight Council to advise the Chief Coroner on whether to call discretionary inquests.

Current Status
1. Amendments to existing Lieutenant Governor in Council (LGIC) Regulation 180 (under Coroner's Act) are being drafted for consideration.

Recommendation
Allow the Chief Coroner the flexibility to assign a lawyer or judge to preside over inquests with complex legal issues.

Current Status
1. Requires legislative change. Timing is pending appropriate legislative vehicle.

Recommendation
Make inquest verdicts and recommendations easily accessible to the public.

Current Status
1. Verdicts and recommendations from 2014 onward are available on the Ministry of Community Safety and Correctional Services' website (earlier verdicts and recommendations are available on CanLii)

Contact Us

For inquiries regarding the Council, please write to:

Death Investigation Oversight Council
25 Grosvenor Street, 15th floor
Toronto, Ontario
M7A 1Y6

We can also be reached by email at DIOC@ontario.ca or by telephone at 1-855-240-3414 or 416-212-8443.